CARROLL COUNTY HEALTH DEPARTMENT
ADDICTIONS REGISTRATION

Name:
First_____ Middle_____ Last_____

Address_____

City_____ Zip Code_____

Home Phone_____ Cell Phone_____

Social Security Number_____ Sex: Male ☐ Female ☐

Date of Birth_____ Age_____ Marital Status ☐ NM ☐ M ☐ D ☐ Sep ☐ Wid

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White

Are you Hispanic or Latino? ☐ Yes ☐ No Citizenship _____

Formal Education Completed_____ ☐ Diploma ☐ GED ☐ AA Degree ☐ BA Degree ☐ MA Degree

Veteran Status_____ Number of dependents_____

Are you Pregnant? ☐ Yes ☐ No Primary Language_____ Interpreter Needed ☐ Yes

☐ Unemployed ☐ Employed ☐ FT ☐ PT by: _____

Emergency Contact Person –

Name:_____ Relationship_____

Address:_____

Phone: _____

Are you currently in treatment? ☐ Yes ☐ No Where?_____

Primary Drug of Choice_____ ☐ Injected ☐ Smoked ☐ By Mouth ☐ Snorted

Source of Referral_____ Are you Court Ordered? ☐ Yes ☐ No

Do you have a regular medical doctor? Name:_____

Do you have a regular dentist? Name:_____

Check any that apply: Temporary Cash Assistance ☐ Primary Adult Care (PAC) ☐ Health Insurance ☐

Medicare ☐ Medicaid ☐ None ☐

Insurance Carrier_____

_____ _____

Patient Signature Date Witness Date